State: *Illinois* ***Filing Company:*** *The Doctors Company, an Interinsurance Exchange*

TOI/Sub-TOI: *11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations*

Product Name: *Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program*

Project Name/Number: *Illinois Rule Revision/*

Filing at a Glance

Company:	The Doctors Company, an Interinsurance Exchange
Product Name:	Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program
State:	Illinois
TOI:	11.2 Med Mal-Claims Made Only
Sub-TOI:	11.2000 Med Mal Sub-TOI Combinations
Filing Type:	Rule
Date Submitted:	05/15/2012
SERFF Tr Num:	DCTR-128335938
SERFF Status:	Closed-Filed
State Tr Num:	DCTR-128335938
State Status:	
Co Tr Num:	2012-IL-01
Effective Date Requested (New):	07/01/2012
Effective Date Requested (Renewal):	07/01/2012
Author(s):	Michael O'Donohue
Reviewer(s):	Gayle Neuman (primary)
Disposition Date:	08/09/2012
Disposition Status:	Filed
Effective Date (New):	
Effective Date (Renewal):	

State Filing Description:

State: Illinois **Filing Company:** The Doctors Company, an Interinsurance Exchange

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program

Project Name/Number: Illinois Rule Revision/

General Information

Project Name: Illinois Rule Revision
Project Number:
Reference Organization:
Reference Title:
Filing Status Changed: 08/09/2012
State Status Changed:
Created By: Michael O'Donohue
Corresponding Filing Tracking Number: DCTR-128335610 (2012-IL-MPL01)

Status of Filing in Domicile: Not Filed
Domicile Status Comments: rates and rules vary by state
Reference Number:
Advisory Org. Circular:
Deemer Date:
Submitted By: Michael O'Donohue

Filing Description:

THE DOCTORS COMPANY, AN INTERINSURANCE EXCHANGE (TDC)
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS PROFESSIONAL LIABILITY INSURANCE PROGRAM
RULE REVISION

We are submitting a rule revision for the captioned program. Based on TDC's current book of business, the overall rate level impact of this revision for all specialties and territories combined is -6.1%.

This revision consists of ithe following changes:

1) claims-free discount rule has been revised in its entirety (See Section 2-Pages IL-E-4 and IL-E-5 of Rules and Rates Manual)

2) Extended Reporting Period Coverage premium charge has been reduced from 230% to 200% (285% to 250% for policies written on a “demand basis”) (See Section 2-Page IL-E-1 of Rules and Rates Manual). Revised Endorsement MPL101IL (7-12)-Illinois Changes reflecting the revised ERP Coverage premium charge has been submitted concurrently in SERFF Filing Number DCTR-128335610 (2012-IL-MPL01).

The Illinois General Rules Exception Pages included in this revision replace all previously filed Illinois General Rules Exception Pages. For comparison purposes, we have enclosed a copy of the new Illinois General Rules Exception Pages with the changes clearly indicated.

In accordance with your requirements, we have also enclosed the following:

1) Summary Sheet (Form RF-3)
2) required Certification

Company and Contact

Filing Contact Information

Michael O'Donohue, Vice President-Regulatory Compliance
185 Greenwood Road
P. O. Box 2900
Napa, CA 94558

modonohue@thedoctors.com
800-421-2368 [Phone] 1318 [Ext]
707-226-0162 [FAX]

State: *Illinois* **Filing Company:** *The Doctors Company, an Interinsurance Exchange*

TOI/Sub-TOI: *11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations*

Product Name: *Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program*

Project Name/Number: *Illinois Rule Revision/*

Filing Company Information

The Doctors Company, an Interinsurance Exchange
185 Greenwood Road
P.O. Box 2900
Napa, CA 94558
(800) 421-2368 ext. 1318[Phone]

CoCode: 34495
Group Code: 831
Group Name: Doctors Company Insurance
FEIN Number: 95-3014772

State of Domicile: California
Company Type: Property & Casualty
State ID Number:

Filing Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

Per Company: No

Company	Amount	Date Processed	Transaction #
The Doctors Company, an Interinsurance Exchange	$0.00		

State Specific

Refer to our checklists prior to submitting filing (http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm).: Reviewed

Refer to our updated (04/06/2007) SERFF General Instructions prior to submitting filing. They have been updated to clarify what rates and rules are required to be filed as well as what rates and rules are not required to be filed. Also, the "Product Name" is the Filing Title and not the Project Number.: Reviewed

NO RATES and/or RULES ARE REQUIRED TO BE FILED FOR LINES OF COVERAGE SUCH AS COMMERCIAL AUTO (except taxicabs), BURGLARY AND THEFT, GLASS, FIDELITY, SURETY, COMMERCIAL GENERAL LIABLITY, CROP HAIL, COMMERCIAL PROPERTY, DIRECTORS AND OFFICERS, ERRORS AND OMMISSIONS, COMMERCIAL MULTI PERIL just to mention a few. However, a Summary Sheet (RF-3) is required to be filed. Please refer to the State Specific Field below for what rates/rules are required to be filed and to our checklists for specific statutes, regulations, etc. : http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp .: Reviewed

Medical Malpractice rates/rules may now be submitted using SERFF effective January 1, 2012.: Noted

The only rates and/or rules that are required to be filed are Homeowners, Mobile Homeowners, Dwelling Fire and Allied Lines, Workers' Compensation, Liquor Liability, Private Passenger Automobiles, Taxicabs, Motorcycles and Group Inland Marine Insurance which only applies to insurance involving personal property owned by, being purchased by or pledged as collateral by individuals, and not used in any business, trade or profession per Regulation Part 2302 which says in part, "each company shall file with the Director of Insurance each rate, rule and minimum premium before it is used in the State of Illinois.": Noted

When selecting a form filing type for a multiple form filing, use the dominant type from these choices: APP - application; CER - certificate; COF - coverage form; DPS - declaration page; END - endorsement; POJ - policy jacket; ORG - Companies adopting an Advisory or Rating Organization's filing. Example: If you are submitting a policy as well as endorsements, a declaration page and an application, you would select "POL" for policy.: Noted

SERFF Tracking #:	*DCTR-128335938*	***State Tracking #:***	*DCTR-128335938*	***Company Tracking #:***	*2012-IL-01*

State:	*Illinois*	***Filing Company:***	*The Doctors Company, an Interinsurance Exchange*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations*		
Product Name:	*Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program*		
Project Name/Number:	*Illinois Rule Revision/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Gayle Neuman	08/09/2012	08/09/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Gayle Neuman	05/30/2012	05/30/2012

Response Letters

Responded By	Created On	Date Submitted

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Effective Date	Note To Reviewer	Michael O'Donohue	08/08/2012	08/08/2012
effective date	Note To Filer	Gayle Neuman	08/08/2012	08/08/2012
effective date	Note To Filer	Gayle Neuman	08/08/2012	08/08/2012

SERFF Tracking #:	*DCTR-128335938*	***State Tracking #:***	*DCTR-128335938*	***Company Tracking #:***	*2012-IL-01*

State:	*Illinois*	***Filing Company:***	*The Doctors Company, an Interinsurance Exchange*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations*		
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Project Name/Number:	*Illinois Rule Revision/*		

Disposition

Disposition Date: 08/09/2012
Effective Date (New): 07/01/2012
Effective Date (Renewal): 07/01/2012
Status: Filed
Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
The Doctors Company, an Interinsurance Exchange	0.000%	-6.100%	$-1,067,074	764	$17,493,028	17.600%	-20.000%

State: Illinois **Filing Company:** The Doctors Company, an Interinsurance Exchange

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program

Project Name/Number: Illinois Rule Revision/

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/30/2012
Submitted Date	05/30/2012
Respond By Date	06/06/2012

Dear Michael O'Donohue,

Introduction:

This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:

Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used?

Conclusion:

Sign up to get e-mail notification for updates to the Department's website. http://insurance.illinois.gov/RSS/

Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:

http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp

Please submit compliant form(s) no later than the date shown above or the entire filing may be disapproved. Please be advised that when the Director disapproves the form(s) you must immediately cease using the form(s) in Illinois.

Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.

Sincerely,

Gayle Neuman

State: Illinois **Filing Company:** The Doctors Company, an Interinsurance Exchange

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program

Project Name/Number: Illinois Rule Revision/

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/01/2012
Submitted Date	06/01/2012

Dear Gayle Neuman,

Introduction:

This is in response to your May 30, 2012 correspondence regarding the captioned filing.

Response 1

Comments:

Effective January 1, 2008, The Doctors Company began reporting statistical data for its Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program to Insurance Services Office (ISO). Prior to this date, statistical data was reported to the National Independent Statistical Service (NISS).

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

If you have any additional questions, please feel free to contact.

Sincerely,

Michael O'Donohue

State: Illinois **Filing Company:** The Doctors Company, an Interinsurance Exchange

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program

Project Name/Number: Illinois Rule Revision/

Note To Reviewer

Created By:

Michael O'Donohue on 08/08/2012 02:43 PM

Last Edited By:

Gayle Neuman

Submitted On:

08/09/2012 08:03 AM

Subject:

Effective Date

Comments:

Dear Ms. Newman:

In response to you August 8, 2012 "note to filer," this is to advise that The Doctors Company would like to maintain the July 1, 2012 effective date for this revision. Thanks.

State: Illinois **Filing Company:** The Doctors Company, an Interinsurance Exchange

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program

Project Name/Number: Illinois Rule Revision/

Note To Filer

Created By:

Gayle Neuman on 08/08/2012 01:12 PM

Last Edited By:

Gayle Neuman

Submitted On:

08/09/2012 08:03 AM

Subject:

effective date

Comments:

I apologize - I did not mean to indicate the wrong insurance company. The Department of Insurance has completed its review of this filing. Originally, The Doctors Company requested the filing be effective July 1, 2012. Was the filing put in effect on July 1, 2012 or do you wish to have a different effective date? Your prompt response is appreciated.

State: Illinois **Filing Company:** The Doctors Company, an Interinsurance Exchange

TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations

Product Name: Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program

Project Name/Number: Illinois Rule Revision/

Note To Filer

Created By:

Gayle Neuman on 08/08/2012 01:10 PM

Last Edited By:

Gayle Neuman

Submitted On:

08/09/2012 08:03 AM

Subject:

effective date

Comments:

The Department of Insurance has completed its review of this filing. Originally, Medical Protective Company requested the filing be effective July 1, 2012. Was the filing put in effect on July 1, 2012 or do you wish to have a different effective date? Your prompt response is appreciated.

SERFF Tracking #:	*DCTR-128335938*	***State Tracking #:***	*DCTR-128335938*	***Company Tracking #:***	*2012-IL-01*

State:	*Illinois*	***Filing Company:***	*The Doctors Company, an Interinsurance Exchange*
TOI/Sub-TOI:	*11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations*		
Product Name:	*Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program*		
Project Name/Number:	*Illinois Rule Revision/*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Exhibit Name	Rule # or Page #	Rate Action	Previous State Filing Number	Attachments
1		Illinois General Rules Exception Pages	Pages IL-E-1 to IL-E-8 (7-12)	Replacement	2011-IL-01	Illinois General Rules Exception Pages (7-12).pdf Illinois General Rules Exception Pages (7-12)-changes.pdf

THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS

SECTION 2-ILLINOIS GENERAL RULES EXCEPTION PAGES

I. GENERAL GUIDELINES

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing the first paragraph with the following:

In the event of termination of the policy or a Named Insured's coverage under the policy because of cancellation or non-renewal, Extended Reporting Period Coverage may be purchased in order to cover claims reported after the termination date of the coverage, which are based on incidents which happened on or after the retroactive date and prior to the termination date of the coverage. Extended Reporting Period Coverage provides an unlimited extended reporting period.

When Extended Reporting Period Coverage is purchased, the aggregate limit provided under the expiring policy will be reinstated. This aggregate limit applies to the entire Extended Reporting Period Coverage period and is reduced by all amounts the Company pays for damages for claims reported during the entire Extended Reporting Period Coverage period.

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing 1. Premium Calculation and Payment with the following:

1. Premium Calculation and Payment

   The premium for the Extended Reporting Period Coverage is calculated as follows:

   a. If the retroactive date is five or more years before the termination date, the premium for the Extended Reporting Period Coverage will be 200% ("incident" basis) or 250% ("demand" basis) of the annual premium in effect on the termination date of the coverage.

   b. If the retroactive date is less than five years, but more than nine months prior to the termination date, the premium for the Extended Reporting Period Coverage will be 200% ("incident" basis) or 250% ("demand" basis) of the annual premium in effect on the termination date of the coverage, which has been based on premium over the last twelve months factored pro rata with regard to maturity.

   c. If the retroactive date is nine months or less prior to the termination date, the premium for the Extended Reporting Period Coverage will be 200% ("incident" basis) or 250% ("demand" basis) of the annual premium in effect on the termination date of the coverage, which has been multiplied by the factor corresponding to the length of time the coverage was in effect:

      i. One to 30 days .090
      ii. 31-91 days .276
      iii. 92-182 days .520
      iv. 182-273 days .760

   d. The Extended Reporting Period Coverage must be requested and appropriate payment received within thirty days of the termination date of the coverage.

Payment of the premium for the Extended Reporting Period Coverage is due prior to the issuance of the Extended Reporting Period Endorsement. At the option of the insured, the following three payment plans will be available with no interest or installment charges:

- 1 single payment
- 2 payments billed 12 months apart
- 8 quarterly payments over 2 years

As described in (2) and (3) below, premium will be waived for Extended Reporting Period Coverage under certain situations.

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing the first paragraph of 2. Retirement with the following:

The Company may waive the premium for Extended Reporting Period Coverage if a Named Insured:

a. has permanently and completely retired from the practice of medicine; and

b. has been continuously insured under a medical professional liability policy for the five years immediately preceding the date of retirement; and

c. has been continuously insured with the Company or one of its subsidiaries for at least one year immediately preceding the date of retirement.

II. RATING GUIDELINES

Rule B. Sizable Risk Rating is deleted and replaced with the following:

B. Sizable Risk Rating

If an individual risk, before the application of any filed credits/debits, develops an annual premium of at least $100,000 at $1,000,000/$3,000,000 limits and such individual risk presents exposures or hazards different from those contemplated in the rates, rules and coverages filed on behalf of the Company, the otherwise applicable rates, rules and coverages may be modified accordingly. However, the Company must file the rate for this risk with the Illinois Department of Insurance on or before the effective date. The filing must include an explanation of the factors used in determining the rate for the risk.

Rule C. Rating Factors is revised by deleting and replacing 2. Increased Limits Factors with the following:

2. Increased Limits Factors

For all specialties except Chiropractic, the Company offers the following limits of liability: 0.1M/0.4M, 0.25M/1.0M, 0.3M/1.2M, 0.5M/2M, 1M/3M, 2M/5M, 3M/6M, 4M/7M, 5M/8M, 6M/9M, 7M/10M, 8M/11M, 9M/12M, 10M/13M and 11M/14M.

For Chiropractic only, the Company offers the following limits of liability: 0.1M/0.3M, 0.2M/0.6M, 0.25M/0.75M, 0.5M/1.5M, 1M/3M, 2M/5M, 3M/6M, 4M/7M, 5M/8M, 6M/9M, 7M/10M, 8M/11M, 9M/12M, 10M/13M and 11M/14M.

The applicable increased limits factors are shown on the State Rate Pages.

Rule C. Rating Factors is amended by adding the following to 3. Claims-Made Maturity Year:

NOTE: "Incident" Basis Coverage: This form of claims-made coverage provides coverage for a written demand made against the insured, and allows the policy to be triggered by the report to the Company of an incident that the insured believes may later give rise to a claim.

"Demand" Basis Coverage: This form of claims-made coverage is more restrictive than incident basis coverage, because the policy only responds when the insured reports a written demand for damages or a suit to, and provides no coverage for reported incidents.

Rule D. Minimum Premium-Surgicenters is deleted and replaced with the following:

D. Minimum Premium

Healthcare facility policies are subject to a minimum premium of $2,500. All other policies are subject to a minimum premium of $500.

III. ADDITIONAL COVERAGES

Rule A. Ancillary Healthcare Professionals is deleted and replaced with the following:

A. Ancillary Healthcare Professionals

Ancillary healthcare professionals include (but are not limited to) Anesthesiologist Assistants, Nurses, Technicians, Physical Therapists and Psychologists. These ancillaries share limits of liability with a Named Insured. Coverage is provided at no additional charge, except for the following ratable ancillaries:

Physicians Assistant
Surgeons Assistant
Certified Nurse Practitioner
Certified Nurse Midwife
Certified Registered Nurse Anesthetist
Optometrist
Perfusionist

The ancillary healthcare professional may purchase his/her own separate limits of liability. See State Rate Pages for applicable rates. Shared limit coverage is available for 50% less than the separate limits of liability rate.

Rule B. Entities is revised by deleting and replacing the last paragraph with the following:

Shared Limits of Liability Coverage = 2% of each physician's/surgeon's premium

Rule F. Punitive Damages Coverage is deleted.

IV. DISCOUNTS/SURCHARGES

Rule A. Claims-Free Discount is deleted and replaced with the following:

A. Claims-Free Discount

If the Named Insured has been insured with the Company for at least three full policy years immediately preceding the effective date of the policy, a claims-free discount shall be applied based on the following two criteria: 1) the Named Insured's open claim reserves at the time of policy renewal, and 2) the claim payments made in the most recent three calendar years as follows:

RESERVES	PAID INDEMNITY	PAID ALAE	CLAIMS-FREE DISCOUNT
$0	$0	$0	25%
$0	$0	$1 to $20,000	20%
$1 to $50,000	$0	$0	20%
$0	$0	$20,001 to $50,000	15%
$0	$0	Greater than $50,000	10%
$1 to $25,000	$0	$20,001 to $50,000	10%
$1 to $50,000	$0	$1 to $20,000	10%
$25,001 to $50,000	$0	$20,001 to $50,000	5%
$50,001 to $100,000	$0	$0 to $20,000	5%

RESERVES = Open Claim Reserves (Indemnity Losses and Allocated Loss Adjustment Expenses)
PAID INDEMNITY = Paid Indemnity Losses
PAID ALAE = Paid Allocated Loss Adjustment Expenses

If the Named Insured is being insured with the Company for the first time:

- A 15% claims-free discount shall be applied if the Named Insured had no claims reported for the most recent five policy years with their prior insurance carrier(s)
- A 7.5% claims-free discount shall be applied if the Named Insured had only 1 closed claim with no paid indemnity losses for the most recent five policy years with their prior insurance carrier(s)

If the Named Insured has been insured with the Company less than three full policy years immediately preceding the effective date of the policy:

- A 15% claims-free discount shall be applied if the Named Insured had no claims for the most recent five policy years with their prior insurance carrier(s) AND no claims with the Company
- A 7.5% claims-free discount shall be applied if the Named Insured had no claims for the most recent five policy years with their prior insurance carrier(s) AND only 1 open or closed claim with no paid indemnity losses and no paid allocated loss adjustment expenses with the Company
- A 7.5% claims-free discount shall be applied if the Named Insured had only 1 closed claim with no paid indemnity losses for the most recent five policy years with their prior insurance carrier(s) AND no claims with the Company

Any claim that the Named Insured reported to their prior insurance carrier(s) that closed with no paid indemnity losses and no paid allocated loss adjustment expenses shall not be considered a claim for purposes of this rule.

A claims-free discount shall NOT apply to:

- any Named Insured with an imposed surcharge
- part time/quarter time, prep, slotted and auxiliary healthcare professionals
- ancillary healthcare providers (e.g. Physician Assistant, Certified Nurse Practitioner, etc.) that share limits with any Named Insured
- healthcare facilities

Rule D. Risk Management Discount is deleted and replaced with the following:

D. Risk Management Discount

1. A risk management discount of 5% shall be applied for all Named Insureds that participate in risk management activities through a Company approved national, state or local medical association.

2. A risk management discount of 10% shall be applied for all Named Insureds that comply with Company approved specialty-based risk management program requirements within a 12 month period.

3. A risk management discount of 10% shall be applied for all insureds that participate in an onsite risk management analysis conducted by a Company representative.

4. A risk management discount of 5% shall be applied for all insureds that complete five or more topical sections within the Company's Patient Safety Interactive Guide.

Rule E. Deductible Discount is deleted and replaced with the following:

E. Deductible Discount

A Named Insured can elect that a deductible apply on a per claim basis. The deductible options are:

a. $5,000 deductible per claim-3% premium discount
b. $10,000 deductible per claim-5% premium discount
c. $25,000 deductible per claim-12% premium discount
d. $50,000 deductible per claim-19% premium discount
e. $100,000 deductible per claim-30% premium discount

Regardless of limits of liability purchased, the actual deductible dollar discount shall be calculated based on the $1,000,000/$3,000,000 rate reflecting all applicable discounts/surcharges including schedule rating credits/debits.

The deductible is subject to an annual aggregate equal to three times the per claim amount. The deductible applies to damages and claims expenses. Once the deductible has been exhausted, all other claims expenses will be paid in addition to the limits of liability. A physician/surgeon may not increase, decrease or cancel his/her deductible during the course of one policy year.

Rule F. Defense Within Limits of Liability Discount is deleted.

Rule H. Imposed Surcharges is deleted and replaced with the following:

H. Imposed Surcharges

See Appendix-Illinois General Rules Exception Pages

Rule I. Schedule Rating Plan is deleted and replaced with the following:

I. Schedule Rating Plan

This plan applies to all risks and is intended to allow flexibility in determining final premiums where there is a solid underwriting justification for deviating from filed manual rates. The following risk characteristics will be used in determining overall schedule rating plan credits/debits:

Risk Characteristics	Range of Modifications–Credit/Debit
1) Practice Profile	**-15% to +15%**

- Protocols in place for screening, hiring, training, credentialing, supervision and ongoing continuing education of staff.
- Medical record keeping systems including policies and procedures to provide control for advising patients of diagnostic studies, consultation and appointments.
- Degree to which record keeping practices incorporate methods to maintain quality records, referrals and test results.
- Hospital affiliations and privileges are geographically proximate and reflect professional expertise of the office practice.
- Implementation of an electronic record system and degree to which insured incorporates methods to maintain quality records, referrals and test results.
- Entity is certified or accredited by AAAHC, ARC, CAP, TJC or another recognized credentialing body. (**Up to -15% only**)
- Medical license has been revoked, suspended, under investigation, probation action taken, or public letter or reprimand, fine or citation has been issued. (**Up to +15% only**)

2) Loss Control Activities	**-10% to +10%**

- Operational activities reflect consent, referral and discharge processes.
- Quality assurance process exists which reviews patient treatment and unexpected results and integrates solutions into the office practice.
- Participation in a Company approved or CME accredited patient safety educational program other than those set forth in the Risk Management Discount rule. (Up to -10% only)
- Presence of medical review committee and/or claim review committee that meet on a regular basis to review office protocols and procedures. (**Up to -10% only**)
- Full time dedicated manager primarily engaged in risk management and/or loss prevention activities. (**Up to -10% only**)
- Demonstrated evidence of cooperation with Company on claims management and resolution procedures. (**Up to -10% only**)

3) Patient Rapport	**-10% to +10%**

- Patient volume is adequate in relationship to group size and patient distribution. Resources are provided to patients for availability of healthcare during weekends and evenings.
- Patient surveys and complaints are analyzed and integrated into the office practice protocol.
- Displays significant length of time insured with the Company and and/or contribution to the community. (**Up to -10% only**)
- Demonstrates an established, longstanding practice and/or significant degree of experience in their current area of medicine. (**Up to -10% only**)

4) Other Risk Characteristics **-15% to +15%**

- Procedures performed differentiate from physicians of the same class, type, and location of risk. The characteristics differentiate the insured from other members of the same class, or recognition of recent developments with a classification or jurisdiction that are anticipated to impact future loss experience.
- The frequency or severity of claims is greater/less than the expected experience for an insured of the same classification/size or recognition of unusual circumstances of claims in the loss experience. **NOTE:** Does not apply to risks eligible for imposed surcharges and Experience Rating Plan.
- Additional activities undertaken with the specific intention of reducing the frequency or severity of claims. (**Up to -15% only**)
- Demonstrates the willingness to expend the time and capital to include the latest advances in medical treatments and equipment into the practice. (**Up to -15% only**)
- Laboratory, radiological, pharmacy, or optical equipment is up-to-date and well maintained. (**Up to -15% only**)
- Adverse payment history within the last three years. (**Up to +15% only**)

Maximum Credit/Debit for risk characteristics: **-25% to +25%**

Note: The Company must maintain complete files of how and why it applied specific Schedule Rating Plan credits/debits and make these files available to the Illinois Department of Insurance upon request. Specific documentation must be included at the inception of new business and upon each anniversary or renewal date of a policy.

The following additional rules are added:

Premium Payment Plans

Full or appropriate partial payment of the annual policy premium is due on or before the effective date of the policy.

At the option of the insured, the following payment plans with no interest or installment charges will be available:

- 1 single payment due on or before the effective date of the policy
- 4 quarterly installment payments of approximately 25% of the annual premium. The initial installment payment is due on or before the effective date of the policy. Additional installment payments are due 3, 6 and 9 months after the effective date of the policy.
- "9-Pay Plan"-15% down payment is due on or before the effective date of the policy. Additional equal installment payments are due 2, 3, 4, 5, 6, 7, 8 and 9 months after the effective date of the policy.

Any additional premium resulting from changes during the policy period must be spread equally over the remaining installment payments. If there are no remaining installment payments, additional premium resulting from changes during the policy period may be billed separately.

Experience Rating Plan

Eligibility

If a group of physicians/surgeons, before the application of any filed credits/debits, develops an annual premium of at least $250,000 at $1,000,000/$3,000,000 limits, such group will be eligible for experience

rating subject to a review of its exposure characteristics and verification of reliable prior carrier loss and exposure data.

Experience Base

The experience modification is determined from the latest available six report years. If the experience for the full six years is not available, then the total available experience is used subject to a minimum requirement of one complete report year.

The experience period used in generating the modification must end with the year prior to the year in which the experience modification calculation is performed. Loss experience from other companies or self-insurance experience may be used if it is reliable.

Experience Modification Factor

The Experience Modification Factor is calculated in two steps. First, the Expected Loss Based on Experience is credibility-weighted with the Expected Loss Based on Manual Premium to arrive at the Credibility-Weighted Expected Loss. Then the Credibility-Weighted Expected Loss is divided by the Expected Loss Based on Manual Premium to arrive at the Experience Modification Factor.

The Expected Loss Based on Experience is a loss forecast based on the account's own experience. It is calculated by first limiting individual claim indemnities to the basic limit and ALAE on a pro-rata basis, and then trending and developing them to an ultimate, current cost level basis. The total experience period basic limit loss is then divided by the number of Experience Period Exposure Units (base class equivalent) to arrive at a Pure Premium estimate:
Pure Premium = Ultimate Trended Basic Limit Loss / Experience Period Exposure Units.

Losses are trended to six months beyond the policy effective date. The Expected Loss Based on Experience is then found by multiplying the Pure Premium estimate by the Current Exposure Units and an increased limit factor:

Expected Loss Based on Experience = Pure Premium x Current Exposure Units x Increased Limit Factor.

The Expected Loss Based on Manual Premium is determined by calculating the account's manual premium and then multiplying by the Permissible Loss Ratio. The Permissible Loss Ratio is the loss ratio underlying our manual rates. The Credibility-Weighted Expected Loss is then calculated using the following formula:

Credibility-Weighted Expected Loss = [Expected Loss Based on Experience x Credibility Factor] + [Expected Loss Based on Manual Premium x (100% - Credibility Factor)].

Finally, the Experience Modification Factor is calculated using the following formula:

Experience Modification Factor = Credibility-Weighted Expected Loss / Expected Loss Based on Manual Premium -1.00.

THE DOCTORS COMPANY
PHYSICIANS, SURGEONS AND ANCILLARY HEALTHCARE PROVIDERS

SECTION 2-ILLINOIS GENERAL RULES EXCEPTION PAGES

I. GENERAL GUIDELINES

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing the first paragraph with the following:

In the event of termination of the policy or a Named Insured's coverage under the policy because of cancellation or non-renewal, Extended Reporting Period Coverage may be purchased in order to cover claims reported after the termination date of the coverage, which are based on incidents which happened on or after the retroactive date and prior to the termination date of the coverage. Extended Reporting Period Coverage provides an unlimited extended reporting period.

When Extended Reporting Period Coverage is purchased, the aggregate limit provided under the expiring policy will be reinstated. This aggregate limit applies to the entire Extended Reporting Period Coverage period and is reduced by all amounts the Company pays for damages for claims reported during the entire Extended Reporting Period Coverage period.

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing 1. Premium Calculation and Payment with the following:

1. Premium Calculation and Payment

   The premium for the Extended Reporting Period Coverage is calculated as follows:

   a. If the retroactive date is five or more years before the termination date, the premium for the Extended Reporting Period Coverage will be ~~230~~200% ("incident" basis) or ~~285~~250% ("demand" basis) of the annual premium in effect on the termination date of the coverage.

   b. If the retroactive date is less than five years, but more than nine months prior to the termination date, the premium for the Extended Reporting Period Coverage will be ~~230~~200% ("incident" basis) or ~~285~~250% ("demand" basis) of the annual premium in effect on the termination date of the coverage, which has been based on premium over the last twelve months factored pro rata with regard to maturity.

   c. If the retroactive date is nine months or less prior to the termination date, the premium for the Extended Reporting Period Coverage will be ~~230~~200% ("incident" basis) or ~~285~~250% ("demand" basis) of the annual premium in effect on the termination date of the coverage, which has been multiplied by the factor corresponding to the length of time the coverage was in effect:

      i. One to 30 days .090
      ii. 31-91 days .276
      iii. 92-182 days .520
      iv. 182-273 days .760

   d. The Extended Reporting Period Coverage must be requested and appropriate payment received within thirty days of the termination date of the coverage.

Payment of the premium for the Extended Reporting Period Coverage is due prior to the issuance of the Extended Reporting Period Endorsement. At the option of the insured, the following three payment plans will be available with no interest or installment charges:

- 1 single payment
- 2 payments billed 12 months apart
- 8 quarterly payments over 2 years

As described in (2) and (3) below, premium will be waived for Extended Reporting Period Coverage under certain situations.

Rule G. Extended Reporting Period Coverage is revised by deleting and replacing the first paragraph of 2. Retirement with the following:

The Company may waive the premium for Extended Reporting Period Coverage if a Named Insured:

a. has permanently and completely retired from the practice of medicine; and

b. has been continuously insured under a medical professional liability policy for the five years immediately preceding the date of retirement; and

c. has been continuously insured with the Company or one of its subsidiaries for at least one year immediately preceding the date of retirement.

II. RATING GUIDELINES

Rule B. Sizable Risk Rating is deleted and replaced with the following:

B. Sizable Risk Rating

If an individual risk, before the application of any filed credits/debits, develops an annual premium of at least $100,000 at $1,000,000/$3,000,000 limits and such individual risk presents exposures or hazards different from those contemplated in the rates, rules and coverages filed on behalf of the Company, the otherwise applicable rates, rules and coverages may be modified accordingly. However, the Company must file the rate for this risk with the Illinois Department of Insurance on or before the effective date. The filing must include an explanation of the factors used in determining the rate for the risk.

Rule C. Rating Factors is revised by deleting and replacing 2. Increased Limits Factors with the following:

2. Increased Limits Factors

For all specialties except Chiropractic, the Company offers the following limits of liability: 0.1M/0.4M, 0.25M/1.0M, 0.3M/1.2M, 0.5M/2M, 1M/3M, 2M/5M, 3M/6M, 4M/7M, 5M/8M, 6M/9M, 7M/10M, 8M/11M, 9M/12M, 10M/13M and 11M/14M.

For Chiropractic only, the Company offers the following limits of liability: 0.1M/0.3M, 0.2M/0.6M, 0.25M/0.75M, 0.5M/1.5M, 1M/3M, 2M/5M, 3M/6M, 4M/7M, 5M/8M, 6M/9M, 7M/10M, 8M/11M, 9M/12M, 10M/13M and 11M/14M.

The applicable increased limits factors are shown on the State Rate Pages.

Rule C. Rating Factors is amended by adding the following to 3. Claims-Made Maturity Year:

NOTE: "Incident" Basis Coverage: This form of claims-made coverage provides coverage for a written demand made against the insured, and allows the policy to be triggered by the report to the Company of an incident that the insured believes may later give rise to a claim.

"Demand" Basis Coverage: This form of claims-made coverage is more restrictive than incident basis coverage, because the policy only responds when the insured reports a written demand for damages or a suit to, and provides no coverage for reported incidents.

Rule D. Minimum Premium-Surgicenters is deleted and replaced with the following:

D. Minimum Premium

Healthcare facility policies are subject to a minimum premium of $2,500. All other policies are subject to a minimum premium of $500.

III. ADDITIONAL COVERAGES

Rule A. Ancillary Healthcare Professionals is deleted and replaced with the following:

A. Ancillary Healthcare Professionals

Ancillary healthcare professionals include (but are not limited to) Anesthesiologist Assistants, Nurses, Technicians, Physical Therapists and Psychologists. These ancillaries share limits of liability with a Named Insured. Coverage is provided at no additional charge, except for the following ratable ancillaries:

Physicians Assistant
Surgeons Assistant
Certified Nurse Practitioner
Certified Nurse Midwife
Certified Registered Nurse Anesthetist
Optometrist
Perfusionist

The ancillary healthcare professional may purchase his/her own separate limits of liability. See State Rate Pages for applicable rates. Shared limit coverage is available for 50% less than the separate limits of liability rate.

Rule B. Entities is revised by deleting and replacing the last paragraph with the following:

Shared Limits of Liability Coverage = 2% of each physician's/surgeon's premium

Rule F. Punitive Damages Coverage is deleted.

IV. DISCOUNTS/SURCHARGES

Rule A. Claims-Free Discount is deleted and replaced with the following:

A. Claims-Free Discount

~~A 15% claims-free discount shall be applied on the effective date of the policy for each Named Insured meeting all of the following criteria:~~

~~Named Insured is an~~If the Named Insured has been insured with the Company for at least three full policy years immediately preceding the effective date of the policy, a claims-free discount shall be applied based on the following two criteria: 1) the Named Insured's open claim reserves at the time of policy renewal, and 2) the claim payments made in the most recent three calendar years as follows:

RESERVES	PAID INDEMNITY	PAID ALAE	CLAIMS-FREE DISCOUNT
$0	$0	$0	25%
$0	$0	$1 to $20,000	20%
$1 to $50,000	$0	$0	20%
$0	$0	$20,001 to $50,000	15%
$0	$0	Greater than $50,000	10%
$1 to $25,000	$0	$20,001 to $50,000	10%
$1 to $50,000	$0	$1 to $20,000	10%
$25,001 to $50,000	$0	$20,001 to $50,000	5%
$50,001 to $100,000	$0	$0 to $20,000	5%

RESERVES = Open Claim Reserves (Indemnity Losses and Allocated Loss Adjustment Expenses)
PAID INDEMNITY = Paid Indemnity Losses
PAID ALAE = Paid Allocated Loss Adjustment Expenses

If the Named Insured is being insured with the Company for the first time:

- A 15% claims-free discount shall be applied if the Named Insured had no claims reported for the most recent five policy years with their prior insurance carrier(s)
- A 7.5% claims-free discount shall be applied if the Named Insured had only 1 closed claim with no paid indemnity losses for the most recent five policy years with their prior insurance carrier(s)

If the Named Insured has been insured with the Company less than three full policy years immediately preceding the effective date of the policy~~.~~:

- ~~Cumulative outstanding~~A 15% claims ~~reserves (~~-free discount shall be applied if the Named Insured had no claims for the most recent five policy years with their prior insurance carrier(s) AND no claims with the Company
- A 7.5% claims-free discount shall be applied if the Named Insured had no claims for the most recent five policy years with their prior insurance carrier(s) AND only 1 open or closed claim with no paid indemnity losses and no paid allocated loss adjustment expenses~~) less than $20,000.~~ with the Company

- ~~Cumulative claim payments (indemnity and~~ A 7.5% claims-free discount shall be applied if the Named Insured had only 1 closed claim with no paid indemnity losses for the most recent five policy years with their prior insurance carrier(s) AND no claims with the Company

Any claim that the Named Insured reported to their prior insurance carrier(s) that closed with no paid indemnity losses and no paid allocated loss adjustment expenses) less than $10,000 in the last three full years immediately preceding the effective dates shall not be considered a claim for purposes of the policythis rule.

If the Named Insured is an insured with the Company less than three full years, the claims-free discount shall also be available if the insured has cumulative outstanding claim reserves less than $20,000 (including no outstanding claims reserves with previous carriers) and cumulative claim payments less than $10,000 in the last three full years immediately preceding the effective date of the policy. In order to receive the discount, the insured must submit acceptable documentation of "claims-free" experience from its previous insurance carriers.

A claims-free discount shall NOT apply to:

- any Named Insured with an imposed surcharge
- part time/quarter time, prep, slotted and auxiliary healthcare professionals
- ancillary healthcare providers (e.g. Physician Assistants, Surgeon AssistantsAssistant, Certified Nurse PractitionersPractitioner, etc.) that share limits of liabilitywith any Named Insured
- healthcare facilities

Rule D. Risk Management Discount is deleted and replaced with the following:

D. Risk Management Discount

1. A risk management discount of 5% shall be applied for all Named Insureds that participate in risk management activities through a Company approved national, state or local medical association.

2. A risk management discount of 10% shall be applied for all Named Insureds that comply with Company approved specialty-based risk management program requirements within a 12 month period.

3. A risk management discount of 10% shall be applied for all insureds that participate in an onsite risk management analysis conducted by a Company representative.

4. A risk management discount of 5% shall be applied for all insureds that complete five or more topical sections within the Company's Patient Safety Interactive Guide.

Rule E. Deductible Discount is deleted and replaced with the following:

E. Deductible Discount

A Named Insured can elect that a deductible apply on a per claim basis. The deductible options are:

a. $5,000 deductible per claim-3% premium discount
b. $10,000 deductible per claim-5% premium discount
c. $25,000 deductible per claim-12% premium discount
d. $50,000 deductible per claim-19% premium discount
e. $100,000 deductible per claim-30% premium discount

Regardless of limits of liability purchased, the actual deductible dollar discount shall be calculated based on the $1,000,000/$3,000,000 rate reflecting all applicable discounts/surcharges including schedule rating credits/debits.

The deductible is subject to an annual aggregate equal to three times the per claim amount. The deductible applies to damages and claims expenses. Once the deductible has been exhausted, all other claims expenses will be paid in addition to the limits of liability. A physician/surgeon may not increase, decrease or cancel his/her deductible during the course of one policy year.

Rule F. Defense Within Limits of Liability Discount is deleted.

Rule H. Imposed Surcharges is deleted and replaced with the following:

H. Imposed Surcharges

See Appendix-Illinois General Rules Exception Pages

Rule I. Schedule Rating Plan is deleted and replaced with the following:

I. Schedule Rating Plan

This plan applies to all risks and is intended to allow flexibility in determining final premiums where there is a solid underwriting justification for deviating from filed manual rates. The following risk characteristics will be used in determining overall schedule rating plan credits/debits:

Risk Characteristics	Range of Modifications–Credit/Debit
1) Practice Profile	**-15% to +15%**

- Protocols in place for screening, hiring, training, credentialing, supervision and ongoing continuing education of staff.
- Medical record keeping systems including policies and procedures to provide control for advising patients of diagnostic studies, consultation and appointments.
- Degree to which record keeping practices incorporate methods to maintain quality records, referrals and test results.
- Hospital affiliations and privileges are geographically proximate and reflect professional expertise of the office practice.
- Implementation of an electronic record system and degree to which insured incorporates methods to maintain quality records, referrals and test results.
- Entity is certified or accredited by AAAHC, ARC, CAP, TJC or another recognized credentialing body. (**Up to -15% only**)
- Medical license has been revoked, suspended, under investigation, probation action taken, or public letter or reprimand, fine or citation has been issued. (**Up to +15% only**)

2) Loss Control Activities	**-10% to +10%**

- Operational activities reflect consent, referral and discharge processes.
- Quality assurance process exists which reviews patient treatment and unexpected results and integrates solutions into the office practice.
- Participation in a Company approved or CME accredited patient safety educational program other than those set forth in the Risk Management Discount rule. (Up to -10% only)
- Presence of medical review committee and/or claim review committee that meet on a regular basis to review office protocols and procedures. (**Up to -10% only**)
- Full time dedicated manager primarily engaged in risk management and/or loss prevention activities. (**Up to -10% only**)
- Demonstrated evidence of cooperation with Company on claims management and resolution procedures. (**Up to -10% only**)

3) Patient Rapport **-10% to +10%**

- Patient volume is adequate in relationship to group size and patient distribution. Resources are provided to patients for availability of healthcare during weekends and evenings.
- Patient surveys and complaints are analyzed and integrated into the office practice protocol.
- Displays significant length of time insured with the Company and and/or contribution to the community. (**Up to -10% only**)
- Demonstrates an established, longstanding practice and/or significant degree of experience in their current area of medicine. (**Up to -10% only**)

4) Other Risk Characteristics **-15% to +15%**

- Procedures performed differentiate from physicians of the same class, type, and location of risk. The characteristics differentiate the insured from other members of the same class, or recognition of recent developments with a classification or jurisdiction that are anticipated to impact future loss experience.
- The frequency or severity of claims is greater/less than the expected experience for an insured of the same classification/size or recognition of unusual circumstances of claims in the loss experience. **NOTE:** Does not apply to risks eligible for imposed surcharges and Experience Rating Plan.
- Additional activities undertaken with the specific intention of reducing the frequency or severity of claims. (**Up to -15% only**)
- Demonstrates the willingness to expend the time and capital to include the latest advances in medical treatments and equipment into the practice. (**Up to -15% only**)
- Laboratory, radiological, pharmacy, or optical equipment is up-to-date and well maintained. (**Up to -15% only**)
- Adverse payment history within the last three years. (**Up to +15% only**)

Maximum Credit/Debit for risk characteristics: **-25% to +25%**

Note: The Company must maintain complete files of how and why it applied specific Schedule Rating Plan credits/debits and make these files available to the Illinois Department of Insurance upon request. Specific documentation must be included at the inception of new business and upon each anniversary or renewal date of a policy.

The following additional rules are added:

Premium Payment Plans

Full or appropriate partial payment of the annual policy premium is due on or before the effective date of the policy.

At the option of the insured, the following payment plans with no interest or installment charges will be available:

- 1 single payment due on or before the effective date of the policy
- 4 quarterly installment payments of approximately 25% of the annual premium. The initial installment payment is due on or before the effective date of the policy. Additional installment payments are due 3, 6 and 9 months after the effective date of the policy.
- "9-Pay Plan"-15% down payment is due on or before the effective date of the policy. Additional equal installment payments are due 2, 3, 4, 5, 6, 7, 8 and 9 months after the effective date of the policy.

Any additional premium resulting from changes during the policy period must be spread equally over the remaining installment payments. If there are no remaining installment payments, additional premium resulting from changes during the policy period may be billed separately.

Experience Rating Plan

Eligibility

If a group of physicians/surgeons, before the application of any filed credits/debits, develops an annual premium of at least $250,000 at $1,000,000/$3,000,000 limits, such group will be eligible for experience rating subject to a review of its exposure characteristics and verification of reliable prior carrier loss and exposure data.

Experience Base

The experience modification is determined from the latest available six report years. If the experience for the full six years is not available, then the total available experience is used subject to a minimum requirement of one complete report year.

The experience period used in generating the modification must end with the year prior to the year in which the experience modification calculation is performed. Loss experience from other companies or self-insurance experience may be used if it is reliable.

Experience Modification Factor

The Experience Modification Factor is calculated in two steps. First, the Expected Loss Based on Experience is credibility-weighted with the Expected Loss Based on Manual Premium to arrive at the Credibility-Weighted Expected Loss. Then the Credibility-Weighted Expected Loss is divided by the Expected Loss Based on Manual Premium to arrive at the Experience Modification Factor.

The Expected Loss Based on Experience is a loss forecast based on the account's own experience. It is calculated by first limiting individual claim indemnities to the basic limit and ALAE on a pro-rata basis, and then trending and developing them to an ultimate, current cost level basis. The total experience period basic limit loss is then divided by the number of Experience Period Exposure Units (base class equivalent) to arrive at a Pure Premium estimate:
Pure Premium = Ultimate Trended Basic Limit Loss / Experience Period Exposure Units.

Losses are trended to six months beyond the policy effective date. The Expected Loss Based on Experience is then found by multiplying the Pure Premium estimate by the Current Exposure Units and an increased limit factor:

Expected Loss Based on Experience = Pure Premium x Current Exposure Units x Increased Limit Factor.

The Expected Loss Based on Manual Premium is determined by calculating the account's manual premium and then multiplying by the Permissible Loss Ratio. The Permissible Loss Ratio is the loss ratio underlying our manual rates. The Credibility-Weighted Expected Loss is then calculated using the following formula:

Credibility-Weighted Expected Loss = [Expected Loss Based on Experience x Credibility Factor] + [Expected Loss Based on Manual Premium x (100% - Credibility Factor)].

Finally, the Experience Modification Factor is calculated using the following formula:

Experience Modification Factor = Credibility-Weighted Expected Loss / Expected Loss Based on Manual Premium -1.00.

State: Illinois **Filing Company:** The Doctors Company, an Interinsurance Exchange
TOI/Sub-TOI: 11.2 Med Mal-Claims Made Only/11.2000 Med Mal Sub-TOI Combinations
Product Name: Physicians, Surgeons and Ancillary Healthcare Providers Professional Liability Insurance Program
Project Name/Number: Illinois Rule Revision/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Explanatory Memorandum		
Comments:	See Filing Description on General Information Tab.		

		Item Status:	Status Date:
Satisfied - Item:	Form RF3 - (Summary Sheet)		
Comments:			
Attachment(s):			
Summary Sheet (RF-3).pdf			

		Item Status:	Status Date:
Satisfied - Item:	Certification		
Comments:			
Attachment(s):			
Certification.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Manual		
Comments:	Upon request, Company will provide copy of entire illinois Rules and Rates Manual.		

Form (RF-3) SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective **July 1, 2012**

	(1) Coverage	(2) Annual Premium Volume (Illinois)*	(3) Percent Change (+ or -)**
1.	Automobile Liability		
	Private Passenger		
	Commercial		
2.	Automobile Physical Damage		
	Private Passenger		
	Commercial		
3.	Liability Other Than Auto		
4.	Burglary and Theft		
5.	Glass		
6.	Fidelity		
7.	Surety		
8.	Boiler and Machinery		
9.	Fire		
10.	Extended Coverage		
11.	Inland Marine		
12.	Homeowners		
13.	Commercial Multi-Peril		
14.	Crop Hail		
15.	Other **Medical Malpractice** Line of Insurance	**$17,493, 028**	**-6.1%**

Does filing only apply to certain territory (territories) or certain classes? If so, specify:
No

Brief description of filing. (If filing follows rates of an advisory organization, specify organization):
Rule Revision including (1) revised claims-free discount rule and (2) revised Extended Reporting Period Coverage charge

* Adjusted to reflect all prior rate changes.
** Change in Company's premium level which will result from application of new rates.

The Doctors Company, an Interinsurance Exchange
Name of Company

Michael O'Donohue

Michael O'Donohue-Vice President
Official - Title

H29219D

THE DOCTORS COMPANY,
An Interinsurance Exchange

Certification

We certify that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

David Preimesberger
Treasurer

Jeff Donaldson, FCAS, MAAA
Senior Vice President and Actuary